MILOS DECLARATION

EXHIBIT D

SPECIAL CASE CONFERENCE

NAME: Valerie Young C#: _____ UNIT: 314

REASON FOR CONFERENCE: FREQUENT FALLS

CONFERENCE DATE: April 20, 2005

TEAM ATTENDANCE

NAME	TITLE
Celeste Gulla	ATP Supervisor
Miriam R Kotheres	Chief OT
Daniel T. Cignan	S.P.T.
[illegible]	R.N.
Teresa Dotson	Rehab Ass't
Serge Delgaun	Psy asst
[illegible]	Psy
[illegible]	OA II
[illegible]	SUA III
[illegible]	Rus
[illegible]	COTA/L II
[illegible]	D/A
Milos Joran	MD
[illegible]	VP

SPECIAL CASE CONFERENCE

NAME: Valerie Young
ID#: 090-0032
UNIT: 314
DATE: 4-20-05

SUMMARY OF MEETING

Reason for conference: frequent falls

DISCUSSION:
The team met to discuss Valerie's overall status, since she has exhibited multiple falls over the past year. The most recent fall was 4/15 in the am, where Valerie went down in the shower sustaining a laceration 2.5cm long over the left eyelid. The direct care staff that was assisting Valerie was utilizing the shower chair. Valerie was helped to stand up to be dressed, when she just fell towards one side. The team notes that over the year, Valerie had behavior highs/lows, two psychiatric hospitalizations and numerous medication changes. The physician feels that the most recent falls are contributed to medications which are sedating, and the left foot drop which is more pronounced. Also, when Valerie does not sleep the night before, her unsteadiness is more pronounced. Valerie was seen for her yearly neurology evaluation on 4-7-05 and chronic gait disorder was noted with left foot drop and high steppage gait. Physical therapy is recommended (with evaluation for possible orthosis for left foot), Vitamin B complex supplement and EMG/nerve conduction studies to be performed. The physician reviewed the recommendations made by the neurologist with the team and all agreed. In addition, due to sedation in the morning the psychiatrist and physician recommended lowering her AM dose of Zyprexa from 15mg to 10mg and then possibly to 5mg. All other medications will remain the same, since Valerie has shown improved behavioral response over the past couple of months. We will also refer to OT for a soft helmet for Valerie's protection since she has reinjured the same eyebrow/eyelid area. The team is unsure whether Valerie will tolerate the helmet, as it may cause some agitation; She will be observed closely when the helmet is obtained. As an extra precautionary measure, Valerie will be given a 2:1 during showering and will be escorted to her room to be dressed. [Team noted: whenever lowering Valerie's medications, there is a risk of extreme behavioral instability as a consequence; she will be monitored closely during the time of transition.] The physician recommended the *continued use* of a wheelchair until a) PT can evaluate Valerie, b) the helmet is obtained, c) medications are reduced and d) nerve conduction studies are performed.

RECOMMENDATIONS:
1. Wheelchair for all mobility needs
2. Morning dose of Zyprexa decreased from 15mg to 10mg (then to 5mg if needed)
3. Physical therapy evaluation
4. Referral to OT for helmet
5. Nerve conduction study/EMG testing to be scheduled.
6. 2:1 during showering with escort to bedroom for dressing on her bed.

Prepared by: _____ Date: 4/20/05

Team leader: Kathleen Grendahl Date: 4/20/05

MILOS DECLARATION

EXHIBIT E

Emergency

BROOKLYN DEVELOPMENTAL CENTER

ADAPTIVE EQUIPMENT SHOP WORK REQUEST

Program/RESIDENT Valerie Young WING 314 DAY PROGRAM _____

Requested by Staff/OMH Date 4.26.05

EQUIPMENT to be repaired or modified: _____
(ie. wheelchair, chair, etc.)

SERIAL NUMBER EEJ 245335

What needs to be done or problem description.

Issued Valerie Young wheelchair with:
- padded seat & back cushions
- seat cushion was fuller in depth
- fabricated soft calf support
- adjusted footplate height

Approved _____ Date _____
Physician

Continue on other side or attach additional sheet, if necessary.

DATE Referral received: 4.27.05 DATE Assigned: 4.27.05

AES Assigned: Courtney Rogers DATE Completed: 4.27.05

SIGNATURE OF PERSON RECEIVING EQUIPMENT: [signature] DATE 4.27.05

Total work time in hours:

Material used:		Qty		Qty
	( ) H.D. polyethylene		( ) Leg rests	
	( ) Kydex		( ) Wheels	
	( ) Foam		( ) Armrests	
	( ) Naughahyde			
	( ) Nuts ____ Bolts			
	( ) Webbing			
	( ) Other:			

CQC198

Ferdinad Exh. 2

MILOS DECLARATION

EXHIBIT F

NAME (Last) Young (First) Valeri (MI)	"C" NO./DOIS NUMBER	DATE OF BIRTH	GENDER
ADDRESS BDC	IS CLIENT ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	MEDICARE NUMBER	
CONSULTING SERVICE PT	MEDICAID NUMBER		

PERTINENT CLINICAL HISTORY

PRESENT MEDICAL CONCERNS

L foot drop Please evaluate for PT. ROM to prevent fixed contractures, Also evaluate for splinting Thank You

PRESENT MEDICATIONS

PHYSICIAN Milos Jovan MD 642-6167 Date 04/27/05

REPORT (FINDINGS, DIAGNOSIS, RECOMMENDATIONS)

DATE OF REPORT 5/2/05

A consultation for Ms. Young to P.T. Department by Unit Physician for P.T. evaluation, ROM ex's to left foot to prevent fixed contractures, and also an assessment for the need of Left foot orthesis. Current P.T. assessment showed that Ms. Young has the capability to transfer from wheelchair to mat table with minimal to moderate physical assistance and with verbal prompts. While on the mat table, she can roll from side to side and able to sit up from supine independently. She has good head and trunk control in sitting. She has good sitting balance. She can stand up from the edge of mat table with minimal to moderate physical assistance and able to maintain standing without assistance for two minutes. Inside parallel bars, she can stand up independently with verbal prompts and can maintain standing holding onto the bars. She's able to walk with moderate physical assistance for 50 feet. Outside parallel bars, she's able to walk for 100 feet needing two staff to walk with her since she has a tendency to lean to the staff, and also will lean forward during the course of ambulation. Minimal left foot drop during ambulation observed.

Recommendations: Ms. Young be scheduled for P.T. treatment 2x/week to receive: Mat ex's, ambulation ex's, ROM ex's to both upper and lower extremities. Ms. Young will also be scheduled to see the Orthotist (in his next visit to BDC) for the evaluation of Left foot orthosis. Will follow up.

(USE BACK OF FORM IF NECESSARY)

Signed DTG Grisard Jr. P.T.

FACILITY/AGENCY

OMRDD

CONSULTATION REQUEST

CQC95

MILOS DECLARATION

EXHIBIT G

Kingsbrook Jewish Medical Center

585 Schenectady Avenue, Brooklyn, NY. 11203 * (718) 604-5461

Radiology Report

NAME:	YOUNG, VALERIE	Date of Birth:	08/06/1955		
#:	052937	Sex:	F		
Dial/Pt#:	9896150	Date of Exam:	05/05/2005		
Location:	RAD- RADIOLOGY REGISTRATION (descp)		Date of Order:	05/05/2005	10:30
Attending MD:	JOVAN MILOS	Ordered By:	JOVAN MILOS		
Adm/Reg:	May 5 2005 10:23AM	Referred By:	UNASSIGNED		
Discharge:		Accession #:	337521		

Final Report

CLINICAL HISTORY: \ pain

XRY 0921 - LUMBAR SACRAL COMPLETE - May 5 2005

REASON FOR EXAM: Pain.

FINDINGS: Radiographic examination of the lumbosacral spine was performed in AP, lateral, and coned-down views.

There is narrowing and sclerosis with bridging osteophytosis noted at the L5-S1 level with mild osteophytosis seen at the other lumbar levels. The other intervertebral disc spaces appear well maintained. The foramina appear patent. Sclerosis is noted at the facet joint especially noted at the L5-S1 level. There is no evidence of fracture or dislocation.

IMPRESSION: Degenerative changes specifically noted at the L5-S1 level. No fracture or dislocation. If pain persists, we would recommend CT or MR.

05/12/05

Interpreting Physician: LAMONT D. BROWN M.D. May 7 2005 8:46A
Transcribed by / Date: PSC on May 7 2005 4:16P
Approved Electronically by / Date: HODGES JASON L May 9 2005 8:29A

CQC92

NAME (Last) Yaung (First) Valery (MI)	C NO /DOIS NUMBER	DATE OF BIRTH 08/06/55	GENDER F
ADDRESS BDC 314	IS CLIENT ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	MEDICARE NUMBER	
CONSULTING SERVICE Radiology KJMC	MEDICAID NUMBER BZ66389C		

PERTINENT CLINICAL HISTORY

PRESENT MEDICAL CONCERNS Fax X-Ray L-S spine

PRESENT MEDICATIONS

PHYSICIAN Milos Jovan MD 642-6124 Date 05/03/05

REPORT (FINDINGS, DIAGNOSIS, RECOMMENDATIONS) DATE OF REPORT

X-RAY
EXAM: L-S SPINE
DATE: 05/03/05 TIME: BY: CR

Signed

(USE BACK OF FORM IF NECESSARY)

FACILITY/AGENCY	OMRDD CONSULTATION REQUEST	CQC93

MILOS DECLARATION

EXHIBIT H

Form 95 DVP (1-77) page 2

DATE	NOTES
	Valerie Young
05/20/05	Consumer sustained laceration on posterior scalp about 2 inches long. Area irrigated with H_2O, shaved, infiltrated with Lidocaine 1% and sutured with 3-0 gut x 4. Hemostasis achieved. Bacitracin ointment applied. To give Keflex 500mg Q6h PO x 5 days.
05/26/05	EMG study under sedation scheduled for 06/30/05 1 : Downstate Hosp. (DR MACARI)
05/27/05	Bilateral pretibial pitting edema 1+ also Bilateral feet pitting edema 1+. No calf swelling & discoloration & tenderness. No negative on Homan's test. Pt with prolonged pitting edema problem in the past also. Venous insufficiency dependent (sitting in wheelchair). To continue with leg elevation.
05/31/05	No new injury marks.
05/31/05	EKG 05/05/05 match. Reversed of arm leads. To repeat
6/19/05	B/2 Responded immediately to Code Blue Wing 314
5:35pm	Pt was lying in the bathroom. Pulse was feeble. B/P 110
	O2 ...

Form 95 DVP (1-77) page 2

DATE	NOTES
05/20/05	Consumer sustained laceration on posterior scalp about 2 inches long. Area irrigated with H2O2, shaved with, infiltrated with Lidocaine 1%. and sutured with 3-0 suit x 4 Hemostasis achieved Bacitracin ointment applied. To give Keflex 500mg Q6h PO x 5 days.
05/26/05	EMG study under sedation scheduled for 06/30/05 1st Doctors Hosp. (DR MACOR)
05/25/05 - 32	Bilateral pretibial pitting edema ++ also bilateral feet pitting edema 1+. No calf swelling & discoloration & tenderness. No reaction on Homans test. Pt with pretibial/feet pitting edema problem in the past also. Venous insufficiency postural (sitting in wheelchair) To continue with leg elevation.
05/24/05	32 No new injury works.
05/24/05	EKG 05/05/05 notch Reversal of arm leads.
6/19/05	To repeat BP 2 Responded immediately to 350mg Cycle B/c wing 314 Pt was lying in the bathroom Pulse was feeble 91 BP 110/ 02 sat 5 l rm 17

MILOS DECLARATION

EXHIBIT I

OFFICE OF CHIEF MEDICAL EXAMINER
CITY OF NEW YORK

REPORT OF AUTOPSY

Name of Decedent: Valerie Denise Young **M.E. Case #:** K05-03154

Autopsy Performed by: Frede I. Frederic, M.D. **Date of Autopsy:** June 20, 2005

FINAL DIAGNOSES

I. PULMONARY EMBOLISM, BILATERAL.
- DEEP VEINS THROMBOSIS OF LOWER EXTREMITIES.

II. SEIZURE DISORDER, ETIOLOGY UNDETERMINED, BY HISTORY.

OPINION:

CAUSE OF DEATH:	**PULMONARY EMBOLISM.**
DUE TO:	**DEEP VEINS THROMBOSIS OF LOWER EXTREMITIES.**
DUE TO:	**INACTIVITY DUE TO SEIZURE DISORDER OF UNDETERMINED ETIOLOGY.**
MANNER OF DEATH:	**NATURAL.**

OFFICE OF CHIEF MEDICAL EXAMINER
CITY OF NEW YORK

REPORT OF AUTOPSY

CASE NO. K05-03154

I hereby certify that I, Frede I. Frederic, M.D., City Medical Examiner - I, have performed an autopsy on the body of ***Valerie Denise Young****, on the 20th day of June, 2005, commencing at 2:00 PM, in the Brooklyn Mortuary of the Office of Chief Medical Examiner of the City of New York.*

This autopsy was performed in the presence of Dr. Gutierrez.

EXTERNAL EXAMINATION:
The body is that of a well developed, well nourished Black female weighing 150 lb, measuring 67" and appearing to be the stated age of 49 years old. The body is cold and nude. Rigor mortis is well developed and present to an equal extent in all joints. Non-fixed, purple livor mortis is evident over the posterior parts of the body, except in areas exposed to pressure where it is absent. The head and face exhibit no trauma. The head hair is black/gray, of a short length and has a corn row style. The eyes are brown with pink conjunctivae. The corneae and lenses are transparent. The pupils are regular, round, equal, central and measure .4 cm in diameter. The ears and external auditory canals are unremarkable. The skeleton of the nose is intact. The gums are unremarkable. The upper and lower teeth are natural and in a good state of dental repair. Some upper and lower teeth are absent. The neck is symmetrical and unremarkable. The shoulders are symmetrical. The chest is symmetrical and unremarkable. The breasts are symmetrical and unremarkable. The abdomen is slightly convex and no masses can be palpated through the abdominal wall. The back is symmetrical and unremarkable. The external genitalia and the anus are unremarkable. The extremities are symmetrical and unremarkable. The fingernails are short, clean and unremarkable. The toenails are short, clean and partly painted with nail polish. The skin of the legs exhibits no dystrophic changes. No edema is present in the ankles or legs. No jewelry, rings, or watch is present. Passive motion of the neck, shoulders, elbows, wrists, fingers, hips, knees and ankles fails to elicit any bony crepitus or abnormal motion.

There is no evidence of recent trauma.

EVIDENCE OF RECENT MEDICAL TREATMENT:
EKG pads are noted on the anterior chest wall. An endotracheal tube is inserted in the oral cavity.

There are no other identifying features.

INTERNAL EXAMINATION:

BODY CAVITIES: The body is opened by a Y-shaped incision. The muscles of the chest and abdominal wall are normal in color and consistency. The ribs exhibit no fractures. The pleural cavities are smooth and each cavity is dry. The liver and spleen do not extend below the costal margins. The bladder lies below the symphysis pubis. The organs of the pleural and peritoneal cavities are in their usual positions in situ.

NECK: The soft tissues of the neck, thyroid and cricoid cartilages, larynx and hyoid bone show no hemorrhage or evidence of traumatic injury. The larynx is patent and no obstructions are found. The epiglottis and vocal cords are unremarkable.

CARDIOVASCULAR SYSTEM: The heart weighs 400 gm. The pericardium contains a scant amount of clear liquid. The epicardial surface is smooth. The external configuration of the heart is unremarkable. The right and left ventricles are unremarkable. The endocardium and valve leaflets are smooth, transparent and exhibit no thrombi, vegetations or fibrosis. The left papillary muscles are slightly hypertrophic. The trabeculae carneae and remainder of the papillary muscles are unremarkable. The chordae tendineae are usual. The coronary arteries have their usual distribution with a right predominance. The coronary ostia are normal in patency. The coronary arteries are unremarkable. The myocardium is firm, dark brown and homogeneous. The aorta exhibits minimal atherosclerotic changes. The venae cavae are unremarkable.

RESPIRATORY SYSTEM: The right lung weighs 450 gm and the left lung weighs 420 gm. The tracheal mucosa is unremarkable. The pleurae are delicate and glistening. The lungs are distended and are variegated pink/gray to dark purple. The lung parenchyma is of the usual consistency and mottled with a slight amount of anthracotic pigment. No nodularity and no focal or diffuse lesions are seen. The extra and intrapulmonary bronchi are congested. The pulmonary arteries are occluded by a black coiled saddle emboli. The blood clot extends to the small branches of the pulmonary arteries. The pulmonary veins exhibit no pathological change. The hilar and mediastinal lymph nodes are unremarkable.

HEPATOBILIARY SYSTEM: The liver weighs 2350 gm. The capsule of Glisson is transparent. The external surface is smooth, glistening and reddish brown. The borders are sharp. The parenchyma is firm and brown with the usual lobular architecture and no focal or diffuse lesions. The gallbladder has delicate walls and contains a moderate amount of bile and has a smooth mucosa. No stones are present. The intra and extrahepatic biliary ducts are patent. The hepatic and portal veins and the hepatic artery are unremarkable.

HEMOLYMPHATIC SYSTEM: The spleen weighs 250 gm and is firm. The capsule is glistening and unremarkable. The internal architecture is clearly defined.

GASTROINTESTINAL SYSTEM: The esophagus is empty and unremarkable. The stomach contains a large amount of partly digested food. The remainder of the gastrointestinal system is unremarkable. The appendix is identified.

UROGENITAL SYSTEM: Each kidney weighs 150 gm. The surfaces are smooth and glistening. The capsules strip easily revealing a red-brown surface. The corticomedullary junction is well defined. The calyceal and collecting systems are not remarkable. The renal arteries and veins are unremarkable. The ureters are not dilated or obstructed. The bladder is empty. The bladder exhibits the usual mucosa and muscularis. The ureteral orifices are patent. The vaginal canal is patent. The cervix is not remarkable. The uterus is not enlarged and is of the usual shape. The endometrial and endocervical cavities are not remarkable. The myometrium is not remarkable. The adnexae are not remarkable.

ENDOCRINE SYSTEM: The adrenals, thyroid, pancreas and pituitary are not remarkable.

MUSCULOSKELETAL SYSTEM: There are no gross bony deformities. The muscles are well developed and of the usual color and consistency. The sternum, ribs and spine exhibit the usual bone density and marrow.

LOWER EXTREMITIES: Posterior dissection of the lower extremities shows deep vein thrombosis.

CENTRAL NERVOUS SYSTEM: The scalp is reflected and the calvarium removed revealing no evidence of trauma. The dura mater does not exhibit any stains or discolorations. The leptomeninges are not remarkable. The brain is fixed in formalin for further study. The skull is intact.

Sample of blood, bile, gastric content, brain, liver and vitreous are submitted for toxicology.

Sample of blood is submitted for serology.

Frede Frederic

Frede I. Frederic, M.D.
City Medical Examiner - I
08/03/05

FF:wwd
DRAFT: 06/22/05:jg
FINAL: 07/26/05:jg
56703

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The City of New York
Office of Chief Medical Examiner
520 First Avenue
New York, NY 10016

Forensic Toxicology Laboratory

Deceased: **Valerie Young** M.E. Case No.: **K0503154** Lab. No.: **2726/05**

Autopsy By: Dr. Frederic Autopsy Date: 06/20/05

Specimens Received:
Blood, Bile, Brain, Gastric Content, Liver, Vitreous Humour

Specimens Received in Laboratory By: Samantha Rappa Date Received: 06/21/05

Equivalents: 1.0 mcg/mL = 1.0 mg/L = 0.1 mg/dL = 1000 ng/mL 1.0 mcg/g = 1.0 mg/kg = 0.1 mg/100g = 1000 ng/g

Results

Blood

Olanzapine	0.24 mg/L	GC
Olanzapine	Detected	GC/MS
Mirtazapine	<0.1 mg/L	GC
Mirtazapine	Detected	GC/MS
Carbamazepine	9.4 mg/L	LC
Carbamazepine	Detected	GC/MS
Lidocaine	Detected	GC/MS
Iminostilbene	Detected	GC/MS
Formyl-acridine	Detected	GC/MS
Ethanol	Not detected	GC
Opiates	Not detected	EI
Benzoylecgonine	Not detected	EI
Amphetamines	Not detected	EI
Barbiturates	Not detected	LC
Phenytoin	Not detected	LC

CT = Color Test
GC = Gas Chromatography
ISE = Ion Selective Electrode
RIA = Radio Immunoassay
TLC = Thin Layer Chromatography
EI = Enzyme Immunoassay
GC/MS = Gas Chromatography/Mass Spectrometry
LC = Liquid Chromatography
SP = Spectrophotometry
< = Less than

Rev. 3/25/98

Signed: Marina Stajic
Dr. Marina Stajic
Date: 07/13/05 AW

MILOS DECLARATION

EXHIBIT J

Mortality Review – Valerie Young

Date: July 26, 2005

Present
Dr. J. Beer, Q.A. Coordinator
Dr. J. Milos, BDC Physician
Dr. N. Mirza, BDC Physician
Dr. V. Capati, BDC Neurologist
Dr. S. Delbrune, Psychiatrist
Dr. S. Palaganas, BDC Physician
Dr. V. Sharobeem, BDC Physician
Dr. I. Madhoun, BDC Physician
Dr. J. Bautista, BDC Physician
Dr. J. Hahn, BDC Psychiatrist
Jan Williamson, DDO
Rev. Robinson

Valerie Young was a 49 year old African American woman of the Protestant faith who functioned at the profound level of mental retardation. Prior to her death Ms. Young resided in unit 3-1 at BDC where she lived since her admission on September 26, 1990. Her mother, Viola Young was her correspondent. Valerie's family was very concerned and involved in her care.

Valerie was the second of three siblings born to her parents Viola and Sidney Young. There is no other history of MR in the family. Prior to her admission to BDC Valerie lived at home with her family. Valerie was the product of a normal pregnancy and delivery. Her mother noted developmental delays as Valerie had no speech by age two and was not toilet trained until she was 4½ years old. At the age of 13 she developed seizures. While she lived with her parents Valerie attended program at AHRC until age 21 and then at YAI until her admission to BDC.

Valerie was alert and aware of her environment. She was able to follow simple directions and recognized people she was familiar with. She was able to communicate with short 1 to 4 word phrases and gestures. She had a very low frustration tolerance and was on behavioral interventions for aggression, disruption and non-compliance. She required supervision and assistance with all of her ADL's.

Prior to her death Valerie was diagnosed with the following:

- Profound Mental Retardation
- Schizoaffective Disorder
- Seizure Disorder
- Tardive Diskinesia
- Constipation
- Melanosis coli
- Brachial plexus neuropathy
- Peroneal neuropathy

Her medications while at BDC were:

- Inderal 80mg TID
- Klonopin 0.5mg HS
- Topomax 100mg BID
- Prevacid 15mg HS
- Vitamin B Complex 1 Tab OD
- Fleet enema three times per week
- Remeron 45mg HS
- Zyprexa 5mg AM & 20mg HS
- Tegretol 400mg AM, PM and HS
- Colace 200mg HS
- Metamucil 2 tsp HS

Valerie's medical history indicates that she had a lymph node biopsy in November, 2000 with negative results. She also had a hemoroidectomy in 1998. In 2002 she had a fracture of the right index finger. Additionally, in 8/01 she had a venous duplex and echocardiogram which were both normal. Valerie had a chronic history of psychiatric decompensations and hospitalizations. On 8/10/04 she was hospitalized for aggressive and agitated behavior. She was discharged on 8/23/04 on Clozaril, Tegretol, Topomax, Inderal and Remeron. On 12/1/04 she was again hospitalized because of agitation and aggressive behavior. She was discharged on 12/23/04 at which time the Clozaril was replaced with Zyprexa. Following this she was relatively stable on her medication regime. Klonopin was added to her medications as a sleep aide on 1/12/05. Her constipation problems were managed with bulk laxatives and fleet enemas.

Valerie had a chronic gait problem manifested by a high steppage gait on the right and dragging of the left foot. In March 2005 the left foot drop became prominent. She was seen by the neurologist on 4/7/05 at which time residual brachial plexopathy on the right and left foot drop and high steppage gait on the right was noted. Vitamin B complex was given, Valerie was referred to PT and an EMG/nerve conduction study was advised. On 4/26/05 she was seen by the neurologist and Peroneal Mononeuropathy – foot drop- was diagnosed. X-ray of the LS spine was advised and the EMG with nerve conduction to be done in a hospital setting under sedation because of needed level of pain tolerance and cooperation. The x-ray of the LS spine showed degenerative changes of L5-S1 and no fracture or dislocation. Valerie was seen by PT and scheduled for PT twice weekly. She was also seen by the orthodist for fabrication of a left ankle foot orthosis. The EMG under sedation was scheduled for 6/30/05 at Downstate Medical Center.

Valerie had several falls attributed to her gait problem, sedation from medication and her behavior. On 4/15/05 she fell during her shower and sustained a laceration on her left upper eye lid. As a consequence, her Zyprexa was reduced. On 5/20/05 she fell and sustained a laceration of the posterior scalp. At this point a wheelchair was introduced for times when Valerie was unsteady on her feet and a protective helmet was issued to prevent further injuries.

On 5/27/05 bilateral pitting edema of Valerie's feet was noted. Homan's test was performed and no reaction was noted. Positional venostatis was assumed and it was managed with leg elevation during rest periods. Valerie was also receiving physical therapy and was ambulating in both the residential and program areas. Valerie was subsequently observed complying with leg elevations.

On 6/19/05 at approximately 8:30 PM Valerie collapsed as staff were escorting her to shower following an enema. Despite resuscitative efforts by medical staff, EMS and ER staff at Brookdale Hospital she expired. An autopsy was done and found that the cause of death was a massive pulmonary embolism.

Conclusions

The Mortality Review Committee members discussed this case and noted that Valerie's medication regimen appeared appropriate and would not have predisposed her to a pulmonary embolism. The issue of Valerie's history of mild pitting edema was also discussed and it was noted that in the past diagnostic testing had not revealed reasons for concern. The most recent episode of edema was reviewed and Dr. Milos noted that

bilateral pitting edema, which she had, is an unlikely sign for DVT. He also noted that he had preformed the Homan's test to check for calf pain (potential sign of DVT), with negative results.

It was noted that Valerie was ambulatory but using a wheelchair for transport because of foot drop and gait instability. It was discussed that staff who monitored her may not have encouraged her to walk around because of fear of her falling. Members discussed possible preventative measures for consumers who are at a high risk for DVT's (i.e. smokers, sedentary, non ambulatory). The use of anti coagulants was discussed but was ruled out as a preventative measure because of the high risk of bleeding, particularly in consumers who are prone to falling. Members discussed that for those consumers who are able to walk, staff should be walking with them throughout the day. For consumers who are non ambulatory, elastic stockings or pressure boots could be used as needed or tolerated by the consumer.

Recommendations

1. For sedentary consumers who are ambulatory, or where otherwise indicated, physicians will include orders for staff to walk with the consumers periodically during the day.
2. For non-ambulatory consumers, physicians will consider the use of elastic stockings or pressure boots where tolerated.

Submitted by: _____
Judith Beer, Ph.D.